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HOW MIDWIVES' DISCURSIVE PRACTICES CONTRIBUTE TO THE
MAINTENANCE OF THE STATUS QUO IN ENGLISH MATERNITY CARE

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Abstract

Background
Poor relationships between maternity care professionals still contribute to poor outcomes for childbearing women, although issues concerning power, gender, professionalism and the medicalisation of birth have been identified and discussed as germane to this situation for nearly three decades. While power relationships and communication issues are known to affect the way maternity care professionals in the United Kingdom work together, there has been no study of the interplay between these factors, nor of how semiotic aspects of professionals' communication relate to it**.**

Aim
To explore how NHS midwives' discursive practices relate to the status quo: that is, how they contribute either to maintaining or challenging traditional discourses concerning power, gender, professionalism and the medicalisation of birth.

Method
In a qualitative study within a Critical Discourse Analysis framework, data were collected from maternity care professionals and women within one English maternity unit, through semi-structured interviews and observation of physical behaviour and naturally-occurring conversation.

Findings
Midwives in the unit revealed an inconsistent professional identity, sometimes challenging established hierarchies and power relationships, but often reinforcing traditional notions of gender, professionalism and the medicalisation of birth through their discursive practices.

Conclusions
Given the known effect of wider social factors on maternity care, it is not surprising that the status quo persists, and that problems linked to them are still commonplace. This situation is compounded by the conflicting obligations under which UK midwives are forced to practise. These findings may have implications for midwives' capacity to respond to current challenges facing the profession.

Introduction

The medicalisation and institutionalisation of childbirth have been explored for three decades: see, for example, Oakley (1980), Donnison (1988), De Vries (1993), Kirkham (1996, 2004), Van Teijlingen et al. (1999) and Keating and Fleming (2009). This body of work provides a comprehensive overview of relationships between midwives, medical practitioners and childbearing women in the western world. Moreover, it shows that issues of power, gender, professionalism and the medicalisation of birth affect the quality of relationships between these groups in maternity care.

Power issues and poor communication are known to contribute to ineffective professional relationships in other areas of health and social care (Kennedy, 2001; Laming, 2003, 2009). In maternity care, there is evidence that these factors continue to operate (see, for example, Curtis et al., 2006; Pinki et al., 2007; Keating and Fleming, 2009). It can therefore be argued that the link between communication issues and power relationships in maternity care bears closer exploration.

In this paper, findings are presented from a study conducted between 2004 and 2006 investigating UK midwives' discursive practices, that is, behaviours which incorporate semiotic or communicative elements, and which are related to wider social discourses. The study focused on midwives' intraprofessional and interprofessional relationships, and their interaction with women in their care.

Maternity care and midwifery

Maternity care in the western world has developed through two distinct (although occasionally overlapping) approaches to birth, each involving a particular group of caregivers. In one view, associated mainly with midwifery, birth is considered primarily a social event involving normal physiological processes (Leap, 2004); in the other, associated mainly with medicine, birth is considered an inherently dangerous process requiring control and surveillance (Donnison, 1988; Witz, 1992; Lankshear et al., 2005). In theory, maternity care can be conceptualised as a continuum, with one of these approaches at either end, and practitioners occupying a range of positions between them. However, by the 1960s, the pre-eminence of medicine in western society considerably marginalised the holistic midwifery approach as midwives were absorbed into medically-oriented healthcare systems designed to treat illness (Donnison, 1988; De Vries, 1993).

In the UK, nearly all midwives practise within the National Health Service (NHS). UK maternity care is consequently provided within highly complex, hierarchically structured organisations (NHS 2010). Moreover, midwives as NHS employees are

commonly constrained by practice guidelines based on medical or managerial, rather than midwifery, principles and priorities (Jowitt, 2001; Porter et al., 2007; Ali, 2008). However, UK midwives have a statutory duty to support women's choices regarding how and where they give birth, and to promote the midwifery approach to birth (Nursing and Midwifery Council (NMC), 2004). They are also expected to support midwifery's professionalisation agenda (Warwick, 2010). Adding to this complexity is the legal status of childbearing women, who can decide where to give birth and which options for care to accept, regardless of professionals' opinions (Hewson, 2004).

This situation has resulted in problematic relationships, not only between midwives themselves, but also with other caregivers (see, for example, Meerabeau et al., 1999; Hagelskamp et al., 2003; Farmer et al., 2003; Pollard, 2003, 2005a; Curtis et al., 2006; Pinki et al., 2007; Keating and Fleming, 2009). This constitutes a social problem, as unsatisfactory working relationships in maternity care are known to contribute to poor, and even fatal, outcomes for women and their families (Confidential Enquiry into Stillbirths and Deaths in Infancy, 2001; Confidential Enquiries into Maternal and Child Health (CEMACH), 2004; Revill, 2004; Robertson, 2004; Lewis, 2007).

Power, gender, professionalism

Foucault conceptualised power as being located within a network of social practices containing the potential for points of resistance (du Gay, 1996). The privileging and normalisation of knowledge is considered an accomplishment of power, either maintained or resisted through discursive practices. In maternity care, medical knowledge has been normalised, as evidenced by widespread incorporation of medically-based (rather than midwifery-based) notions of risk and definitions of 'normality' and 'abnormality' (NMC, 2004; Lankshear et al., 2005). In consequence, obstetric practices such as pharmaceutical induction of labour are widespread (Lothian, 2006), while midwifery practices such as supporting homebirth are often considered dangerous (Hagelskamp et al., 2003), despite evidence to the contrary (Duff and Sinclair, 2000; Johnson and Daviss, 2005).

Issues of gender and professionalism are central to power relationships within maternity care. In the western world, gender has been assigned various attributes, traditionally conceptualised as binary opposites, for example, masculine/feminine. (Annandale, 1998). Up until comparatively recently, 'masculine' attributes generally carried positive social value, while many 'feminine' attributes appeared to involve behaviour requiring male control: for example, men were considered to be rational

and strong, while women, in comparison, were seen as irrational and weak (Annandale, 1998; Adkins, 2002). During the nineteenth century, the rise of medicine as a rational 'masculine' science resulted in the irrational 'feminine' becoming pathologised. The effects of this are still discernible in phenomena such as the medicalisation of birth, which can be conceptualised as a gendered process: in many countries, legislation gives medical practitioners power over childbearing women (see, for example, Keating and Fleming, 2009). Kitzinger (2007:91) notes how Hapangama and Whitworth (2006), describing a career in obstetrics and gynaecology, never mention women, but focus 'entirely on intervention, management, technology and surgery'. Pregnancy is therefore equated with pathology, requiring surveillance and management by medically-oriented health professionals to be brought to a safe conclusion (Nettleton, 2006).

For most of the nineteenth century, women could not be 'professionals' like doctors. At the same time, UK midwives were subjected to a deskilling strategy by the medical profession (Witz, 1992). Midwives could only attend women in 'normal' labour, 'abnormal' labour being claimed as a medical domain (Donnison, 1988). Women in 'normal' labour needed only care and support from their attendants, while 'abnormal' labour involved interventions requiring technical or surgical skills. This medical division of practice, although reformalised, still persists (NMC, 2004).

One consequence is the gendered professional hierarchy still operating in NHS maternity care. Although there is a tendency to perceive professionalism as a neutral phenomenon, writers from various feminist traditions have pointed out that men have set the standards through which it is defined (Davies, 1992; Witz et al., 1996). Professional roles therefore have gender value (Porter et al., 2007); this regardless of the physical gender of individuals. Consequently, when women enter occupations originally reserved for men, they often become 'honorary' men to maintain occupational status (Gherardi, 1996). So doctors ('masculine'), of either gender, have higher status than midwives ('feminine'). As they are not considered to rank with 'professionals', childbearing women are at the bottom of the hierarchy.

Social changes

More recent social changes have also affected midwives' working environments. Workplace feminisation, supporting workplace semiotics that encourage more 'feminine' modes of communication and self-presentation (Adkins, 2002), has resulted in some operational flattening of the NHS hierarchy. The ascendancy of the marketplace ethos, the reshaping of power relationships between healthcare professionals and the public, and the regulation of medicine have also changed the

constitution and representation of power in the NHS (Lissauer, 2003; Porter et al., 2007; Nettleton et al., 2008). Nevertheless, the reality of continuing medical control over both midwifery practice and childbirth belies the idea that roles based on traditional notions of gender attributes are yet fundamentally under threat in the NHS.

Midwives' discursive practices and the status quo

Although social factors underlying problematic working in midwifery have been identified and debated for nearly thirty years, little attention has been paid to the semiotics of communication, both verbal and non-verbal, between different maternity care professionals, and between midwives themselves. Some authors have highlighted the importance of language used (Hunter, 2006; Furber and Thomson, 2010). However, the focus has been mainly on communication between professionals and childbearing women, or the conceptualisation of birth itself, rather than on communication between professionals. Therefore, there has been little focus on developing understanding of how midwives' discursive practices influence their professional relationships. The aim of the study reported here was to explore how NHS midwives' discursive practices relate to the status quo: that is, how they contribute either to maintaining or challenging traditional discourses concerning power, gender, professionalism and the medicalisation of birth.

In this context, sociologists define 'discourse' as a framework within which knowledge, practice and values are constituted (du Gay, 1996). However, discourse analysts define 'discourse' as both 'language in use' and 'human meaning-making' (Wetherell, 2001). In this paper, the word 'discourse' refers to the sociologists' definition, other than when discourse analysis is mentioned directly.

Methods

Research design

The importance of language is recognised within critical social theory (Chouliaraki and Fairclough, 1999); consideration of social action is central to critical linguistic theory (Kress, 2001). Critical discourse analysis (CDA), in which these foci fuse, was therefore chosen as an apt framework for studying links between power and communication involving maternity care professionals. Additionally, CDA researchers have a particular interest in how power manifests in relation to social problems (Fairclough, 2001).

CDA researchers collect data which translate easily into 'text', that is, 'representation of social interaction' (Fairclough, 1992). Despite a broad definition of

'text', CDA research methods often focus on documentary material, including interview transcripts (Titscher et al., 2000). This study also needed to capture semiotic detail of the physical environment and of interaction between different professionals. 'Text' extends to photographic and video recordings (Fairclough, 2001); however, using cameras in NHS maternity care settings is problematic, due to ethical considerations and research governance requirements (Department of Health, 2005). Fieldnotes recording observed behaviour and naturally-occurring conversation were therefore also included as 'texts' (Pollard, 2005b).

Ethics

Ethical approval was gained from both University and NHS Research Ethics Committees. Consent was obtained from all participants when recruited to the study. Non-participants were sometimes present during data collection; no observations involving them were recorded.

Setting

The study was conducted in a consultant-led English NHS maternity unit with a history of supporting the extension of occupational roles. This was important, as the blurring of professional/occupational boundaries can be problematic (Rushmer, 2005; Stevens et al., 2007; Sanders and Harrison; 2008).

The unit comprised a central hospital site and a community midwifery service. It employed hospital-based midwives, and community midwives who practised both in hospital and community settings. Other relevant personnel included administrative staff, anaesthetists, auxiliaries, obstetricians, paediatricians and physiotherapists. Liaison also occurred between midwives and community-based professionals, namely, general practitioners (GPs), health visitors, community mental health teams and social workers. Data were collected in the hospital delivery suite and the ward where women were admitted both antenatally and postnatally.

Study instruments and data collection

During three two-week periods over twelve months, observations of interaction between midwives and other staff members, naturally-occurring speech, physical behaviour and details of the physical environment were recorded in fieldnotes. Data were also collected through semi-structured interviews; these allowed participants' responses to reflect their lived reality, which in turn facilitated identification of their discursive practices (Fairclough, 1992). All interviews bar one were audio-recorded and transcribed verbatim.

The midwives' interview guide focused on power and communication. It included general exploration of perceptions concerning professional relationships within the unit, as well as decision-making in relation to hospital policies and to women's choices. Midwives were asked about hospital policies governing dysfunctional labour and the administration of Vitamin K, both issues concerning areas of care on which medical and midwifery perspectives sometimes diverge (Wickham, 2003). The interview also addressed role extension and overlap. All these factors are known to contribute to professional tensions (Meerabeau et al., 1999; Pollard, 2003; Stevens et al., 2007; Sanders and Harrison, 2008). Midwives were also given opportunities to raise other issues; appropriate questions were included in subsequent interviews.

After data collection in the unit was completed, women's perceptions of midwives' interaction with their professional colleagues were also explored. During semi-structured interviews, women were asked about their current/most recent pregnancy in relation to the range of professionals caring for them. The interview focused on communication both across and within hospital and community settings, consistency of information and advice, and responses and reactions to women's expressions of choice concerning their care. The interviews followed individuals' particular experiences in relation to these factors, affording opportunities also to raise other issues.

Sample

Observation

Anyone coming into an area could be recruited to the study. Observations involved thirty-two midwives, four administrative staff, twenty-seven medical staff, five students, ten auxiliaries, six other hospital staff and four women using the service.

Interview - midwives and other professionals

Midwives' interprofessional working differs according to whether they are hospital- or community-based. Given the hierarchical nature of the NHS, the researcher wished to interview both junior and senior staff, as well as midwives engaged in extended roles. The sample for interview was accordingly selected following a strategy of maximum variation (Cresswell, 1998), on the basis of work locale, seniority and role.

The interview sample comprised twenty midwives: three senior midwifery managers; three senior delivery suite midwives; four middle-ranking hospital midwives (two from the delivery suite and two from the ward); three junior hospital midwives (one from the delivery suite and two from the ward); and seven senior

community midwives. One senior delivery suite midwife and three community midwives performed clinical procedures traditionally conducted only by doctors. During observations, it became apparent that this had impacted significantly on the obstetricians' role. Four obstetricians (two consultants and two registrars) were therefore interviewed about this topic. All midwife and obstetrician interviews were conducted in the hospital.

Interview - women using the service

Eight women were recruited to the study, all of whom gave birth either in hospital or at home during the year covering data collection in the hospital. Two were interviewed in the hospital, one at her workplace, and five in their own homes. These women had had a variety of experiences, both positive and negative in their own perceptions, so presented a varied picture of care provision and professional working within the local maternity services.

Data analysis

Both interview and observational data were initially subjected to thematic analysis, entailing organisation into categories and themes (Huberman and Miles, 1994). Appropriate data were subsequently scrutinised according to CDA principles, in order to identify the midwives' discursive practices. CDA aims to elucidate relationships between discourses identified within 'texts' through interactional analysis. In this study, 'texts' comprised all the midwife interview transcripts, and fieldnote data incorporating direct speech and/or semiotic details of physical appearance and non-verbal behaviour. Interactional analysis aims 'to show how semiotic, including linguistic, properties of the text connect with what is going on socially in the interaction' (Fairclough, 2001:240).

Fairclough (2001) suggests identifying four features within a 'text':

- Representation – how social practices are presented and contextualised.
- Relation – how social relations are constructed.
- Identification – how social identities are constructed.
- Valuing – how social values are presented.

Analysis was performed in a manner similar to thematic analysis: each document was coded in terms of categories of social practice, relations, identity and value. Categories were then examined and grouped to produce themes relating to these features.

Findings

Themes identified from the interview and observational data included gender issues, professionalism, orientation to midwifery and interprofessional working.

Gender issues

At the time of data collection, the unit workforce was largely female. Gender signalling was evident in appearance, communication modes and task performance. Some midwives wore small items of jewellery and discreet hair ornaments, and most used cosmetics sparingly. Staff generally enjoyed informal modes of communication. Conversations often focused on stereotypically 'feminine' concerns, particularly their physical appearance/adornment and their immediate family. They also frequently used physical contact when speaking to colleagues of both genders:

> Anaesthetist and receptionist chatting about receptionist's grandchildren...Receptionist, auxiliary, midwife, domestic, Midwife(senior5) – all standing around reception desk, have a discussion about latter's lip gloss.

> Consultant(paediatric1) and Midwife(11) coming down the corridor talking. They stop by the front desk, and Midwife(11) turns to him and puts her hand on his shoulder.

Excerpts from fieldnotes

All midwives often engaged in domestic tasks:

> Midwife(senior 2) and auxiliary are pushing beds and cabinets down the corridor, going backwards and forward, chatting all the time.

Excerpt from fieldnotes

Reflections of the gendered nature of the operating hierarchy were discernible in language use:

> Midwife(senior 5) (speaking to registrar): 'I'll just let the girls (*midwives*) know – where are you going?'

> Midwife(manager1): 'So all Mr. Consultant(obstetric3)'s going to do is tell us what he thinks we should do.'

Excerpts from fieldnotes

Professionalism

All the midwives bar one considered themselves to be 'professionals':

> We're all professionals, we're all sensible, we all know what we're
> supposed to be doing...
>
> *Midwife(junior4)*

Issues of autonomy were particularly important to them. Midwife(senior1) spoke about senior midwives' overseeing junior midwives, but also stated that midwives were given 'full autonomy' in the unit. Respondents differentiated between themselves and obstetric nurses in this regard:

> We're more autonomous in our role than an obstetric nurse.
>
> *Midwife(8)*

Nevertheless, Midwife(8) did not feel that she had 'full autonomy':

> Midwife(8):...normally you go through the senior midwives, and
> that's just the way things are here...without mentioning any names
> or anything like that, I think there are certain people who are
> probably a bit more like the boss than others.
>
> *Midwife(8) interview*

Moreover, midwives did not always behave as 'professionals':

> I asked her (*the midwife*) if I'd be staying...she said ' You know I can't say
> any more than that, 'cos it's more than my job's worth'.   *Woman(1)*

When asked about the unit policy concerning dysfunctional labour, some midwives used language that did not suit the concept of a 'professional':

> Personally I find it, with normality which is what we're experts in, I
> find it quite strict.   *Midwife(junior4)*

> A lot of midwives feel that once they're in hospital, we've got this
> policy [for cervical dilatation] of a centimetre an hour - it's quite
> ludicrous really.   *Midwife(6)*

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Midwives told parents about Vitamin K and administered it to newborn babies. Should parents refuse permission, the policy required their referral to paediatricians or GPs for further discussion. Eighteen midwives considered this a reasonable course of action:

> I agree with that...we have to try and give information in a very unbiased way, and with as much medical knowledge as possible...the parents don't always have the full information and knowledge at their fingertips to make a decision, and so I do feel somebody even more in the know than me can still give them unbiased information...
>
> *Midwife(community1)* (Pollard, 2010:51)

However, two community midwives did not:

> I don't know if it *(Vitamin* K*)* is really necessary .... there must be a reason why they *(babies)* have got low levels of Vitamin K ... I wouldn't argue with a woman that didn't want to give it. *Midwife(community2)*
>
> I just think that's outrageous...some doctor phoning you up at home! ... It's their baby and you can only give them the information... what they do about it is up to them.
>
> *Midwife(community6)*

Some participants felt that midwives should always follow unit policy, irrespective of their own views:

> Had a conversation with Midwife(senior5), Midwife(senior7) and student about informed choice for women. Clear that both midwives...don't approve of midwives giving women their personal opinions if they're different from Trust policies and guidelines.
>
> *Excerpt from research journal*

Orientation to midwifery

All the midwives distinguished between holistic midwifery dealing only with 'normal' women, and midwifery involving extended skills and the care of women with 'complications'. Some midwives valued the skills involving technological and medicalised treatments and procedures more than those required to support

'normal' birth. With very few exceptions, individuals' orientation reflected their place of work, that is, either the community or the hospital.

> In the main unit, they seem to think that they (*the community midwives)* don't do very much, and they don't know what they're doing when they come in here *(to the hospital)*, because they only know about normal things, so they're useless with anything goes wrong, as soon as anything happens that's sort of not normal; and I think they don't have a very high opinion of them.
>
> *Midwife(community4)*

> Midwifery in my heart is really just about that whole fantastic normal thing with women...but it's not that interesting all the time.
>
> *Midwife(senior1)*

Midwives' language often assigned non-adult status to women. When referring to women, midwives and other staff also often used phrases implying ownership:

> Midwife(community2): 'I must speak to the health visitor about one of my girls.'

> Midwife(senior5) on the phone to an anaesthetist, requesting an epidural for a woman: 'She's a lovely little girl, but she's struggling.'

> Auxiliary talking to Midwife(senior5): 'Is your lady going upstairs?'
>
> *Excerpts from fieldnotes*

Despite midwives' statutory obligations, they expressed different views about the need to respect women's choices for care. Most midwives explicitly stated that women's choices should always be respected, although some senior midwives felt it was 'unreasonable' for women to insist on a course of action that challenged medical perceptions of risk and safety. Nevertheless, there was strong management support for respecting women's choices. For example, community midwives were supported in attending a woman giving birth to twins at home, an uncommon situation in the UK, where multiple births, considered 'abnormal' (not merely 'unusual'), generally involve obstetric management in hospital.

Interprofessional relationships

Midwives adopted different positions with regard to their interprofessional relationships. One such position was 'the health professional interacting as an equal with other colleagues', and was evident in most of the midwives' opinions of their relationships with the obstetricians:

> I do think that the consultants and the obstetric teams liaise very well with delivery staff. *Midwife(junior7)*

Some senior midwives, unusually for the UK, conducted ventouse deliveries, and also taught junior obstetricians this skill. This cross-boundary working had affected the power relationships between the midwives and the obstetricians:

> When junior doctors come... it's quite a role reversal...they're only here for a learning experience.
>
> *Midwife(manager1)*

> We say to our juniors 'The midwives know far more than you guys know, and you must respect them and defer to them, they're professionals in their own right'. *Consultant(obstetric1)* (Pollard, 2010:52)

This situation appeared to have affected midwife-obstetrician power relationships more widely:

> Consultant(obstetric3): 'Do you want me to look at the [caesarean section] wound?
> Midwife(manager1): 'I don't know. To Midwife(junior15): How do you think she'll react? She's seen all lady doctors -'
> Midwife(junior15): 'I don't mind, I'll look at it and let you know if I'm not happy with it.'
>
> *Excerpt from fieldnotes*

In this case, it was noticeable that the decision regarding the extent of the consultant's involvement was made by the most junior person present.

Relationships with other medical professionals revealed a second position, that of 'the health professional striving for professional status within the hierarchical system'. Most community midwives reported good relationships with GPs. However,

some friction was reported, as a result of midwives' having recently taken on examination of newborn babies, a task previously only conducted by GPs or paediatricians:

> There's a lot of resistance from one particular surgery in this area, the GPs don't feel that it's an appropriate role for midwives;
>
> *Midwife(community3)*

Relationships between midwives and paediatricians were also difficult. Midwives were obliged to follow paediatric guidelines which they did not always consider appropriate:

> The paediatricians are very hot on doing lots of observations and things on babies, and weighing babies...I hate it. I think it's horrible.
>
> *Midwife(community4)*(Pollard, 2010:57)

The unit's neonatal policies and guidelines were ostensibly made with input from both midwives and paediatricians. However, the final say rested with the paediatric consultants:

> ... sometimes it takes a very forward thinking consultant to say 'Well actually, let's change [policies]'...   *Midwife(manager2)*

All the midwives supported the 'skilling-up' of auxiliaries, who were being trained to take on some traditional midwifery tasks:

> . . . it's basically making their job more interesting, and making them part of the team...   *Midwife(5)*

Discussion

Examination of the findings allowed identification of the midwives' discursive practices which challenged traditional discourses, and those which reinforced them (Figures 1 and 2). Given the way in which power, gender, professionalism and the medicalisation of birth are inextricably intertwined in the dynamics of maternity care, these factors will be discussed together.

The data presented here illustrate the midwives' ongoing construction of their professional identity. For many of them, this was not consistent, a finding similar to

that reported by Porter et al. (2007) in their study of midwives' professional behaviour with respect to decision-making. In the study reported here, the midwives' professional identity, as demonstrated by their discursive practices, altered with areas of care. For example, most of them thought that the policy governing dysfunctional labour, based on medical rather than midwifery perspectives, was not appropriate, demonstrated by the use of words like 'strict' and 'ludicrous'. However, nearly all of them thought it was reasonable to invoke 'better' knowledge, that is, medical knowledge, should parents refuse the administration of Vitamin K for their babies. This example reveals how the midwives sometimes privileged medical knowledge above either their own or that of the women they were supporting. Only two midwives recognised how incongruous it was that the information they offered parents about Vitamin K was considered adequate for them to consent to its administration, but not for them to decline it. One participant equated lack of bias with providing medical knowledge, revealing that medical knowledge had become normalised about this issue, despite being controversial in some quarters (Wickham, 2003). These attitudes to medical knowledge were not surprising, considering that UK midwives' professional guidelines locate them within a medicalised approach to birth (NMC, 2004; Pollard, 2007).

Social value and relations attached to the gendered, medicalised perspective of birth were also apparent in the way that midwives and other staff referred to the women using the service. The word 'lady' applied to a birthing woman helps to maintain a discourse of sanitised birth, in which women are clean and genteel, submissive and restrained, and unlikely to upset established societal patterns. Similarly, terms denoting child-like status reinforce the notion that women cannot manage their own affairs, and that, consequently, female processes need to be managed by men. In the context of giving birth, maternity care professionals become surrogate men for this purpose. Feminist midwives have for a long time been urging their colleagues to avoid discussing 'ladies' or 'girls', but rather to refer to women as 'women' (Leap, 2004; Furber and Thomson, 2010). Interestingly, as found elsewhere (Kirkham, 2000), midwives also referred to themselves and other midwives as 'girls' when in conversation with doctors, thereby reinforcing their own relatively inferior hierarchical position. Despite the apparent feminisation of the working environment and in particular, the flattening of hierarchy through informal modes of communication, no obstetrician was ever referred to as a 'girl', nor was ever observed participating in the domestic tasks which the midwives and auxiliaries commonly shared.

The use of such gendered language, coupled with the discrepancies surrounding their own assessment of their status as 'professionals', indicated that the midwives often regarded themselves as having less status within the organisation than doctors, a fact reflected in their having sometimes to follow medically-based policies, such as those for neonatal care, whatever their professional opinion. Their assertion that they were 'professionals' however, revealed their aspirations in this regard, and therefore their reinforcement of the traditional discourse of professionalism. They seemed generally unaware of possible contradictions arising from being simultaneously a 'professional' and supporting women in their choices (Wilkins, 2000; Pollard, 2005a). Adherence to 'professionalism' was also evident in the way many of them valued medicalised and technological skills above those required to support women in 'normal' labour, findings similar to those reported by Keating and Fleming (2009) and Larsson et al. (2009), as well as Foley and Fairclough (2003), who found that midwife participants in their research drew on medical discourses in order to legitimate their position as professionals. As midwives' remit is expressly to care for women whose pregnancies progress 'normally', this can be interpreted as a strategy of 'vertical substitution' (Nancarrow and Borthwick, 2005), in which one occupational grouping attempts to raise its status by encroaching on another's area of practice. The way in which the balance of power had shifted between the junior obstetricians and the senior midwives, due to the latter's conducting ventouse deliveries, demonstrated this strategy's success. Further evidence for the midwives' support for professionalisation was found in their attitude toward the 'skilling-up' of the auxiliaries, which was regarded as aiding their own practice, rather than threatening it.

Only two community midwives consistently adhered to midwifery perspectives on birth. The other eighteen were inconsistent, supporting midwifery or medical perspectives depending on the circumstances. However, strong managerial support for women's choices meant that the midwifery approach to birth, while not the default option, could be implemented.

All these findings supported the Foucauldian view of power relationships in the unit as comprising a network of shifting and contended social practices. Although this network seemed to be generally stable, some areas of stability appeared to reinforce traditional power relationships (midwives-paediatricians), (junior-senior midwives), while others demonstrated the ascendance of 'new' power relationships (midwives-obstetricians). The inconsistency of the midwives' position within this network was unsurprising, given that the UK midwifery system demands that midwives simultaneously adhere to a medicalised approach to childbirth, act as

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advocates for women, practise according to the midwifery approach, promote the professionalisation of midwifery and observe their contractual obligations as employees (NMC, 2004; Pollard, 2005a, 2007).

As these qualitative findings come from one maternity unit, they do not represent all UK midwives. However, the unit's midwifery management and the midwife-obstetrician relationships undoubtedly supported practices challenging the status quo. As similar conditions cannot be assumed in other UK obstetric-led units, midwives' reinforcement of traditional social discourses may be even more entrenched, generally speaking. If this is so, there is arguably a question mark over midwives' capacity to rise to current challenges facing the profession (Warwick, 2010). More research is required to establish whether or not this is the case.

Conclusion

Midwives in this study revealed inconsistent professional identity, sometimes challenging established hierarchies and power relationships, but often reinforcing traditional notions of gender, professionalism and the medicalisation of birth through their discursive practices. Given the known effect of these factors in maternity care, it is therefore not surprising that the status quo persists, and that problems linked to them are still commonplace. This situation is compounded by the conflicting obligations under which UK midwives are forced to practise. These findings may have implications for midwives' capacity to respond to current challenges facing the profession.

Acknowledgements

Conflict of interest
The author is not aware of any conflict of interest.

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Figure 1. Midwives' discursive practices which challenged traditional discourses

Discursive practice	Effect
Informal behavioural and communication styles	Flattened hierarchy
Cross-boundary clinical practice	Challenged traditional demarcations and power differentials between professions
Support for women's choices concerning their care	Prioritised women's agenda above professional concerns
Support for the midwifery approach to birth	Challenged the medical perspective of birth

Figure 2. Midwives' discursive practices which reinforced traditional discourses

Discursive practice	Social/occupational groups affected
Gender-signalling: appearance, language and gendered tasks	Reinforced the hierarchy/status difference and power differentials between 'male' and 'female' professions, occupations and activities
Valuing of medical and technological skills above those required for attending normal birth	Reinforced the primacy of medical knowledge and medical skills above the skill of providing 'basic' care;
Privileged medical knowledge and medical concepts of risk	Promoted the medical perspective on birth